



### TOPICAL ANTIVIRAL DRUGS PA SUMMARY

<b>PREFERRED</b>	Zovirax 5% cream/ointment
<b>NON-PREFERRED</b>	Acyclovir 5% ointment, Denavir cream, Xerese (acyclovir 5% cream/hydrocortisone 1% cream)

**LENGTH OF AUTHORIZATION:** 1 Year

**PA CRITERIA:**

*For Generic Acyclovir 5% Ointment*

- ❖ Submit a written letter of medical necessity stating the reasons that brand-name Zovirax 5% ointment is not appropriate for the member.

*For Denavir cream*

- ❖ Approvable for members 12 years of age or older with recurrent herpes labialis (cold sores) who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to Zovirax 5% cream.

*For Xerese*

- ❖ Submit a written letter of medical necessity stating the reasons that the preferred products, Zovirax 5% cream and hydrocortisone 1% cream (as two separate prescriptions) are not appropriate for the member.

**EXCEPTIONS:**

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827**.

**PA and Appeal Process:**

- ❖ For online access to the PA process please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

**Quantity Level Limitations:**

- ❖ For online access to the current Quantity Level Limits please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.